Testimony by Senator Judy Robson
on
SB 108: Mandatory Overtime for Health Care Workers
to the
Senate Committee on Health, Health Insurance, Privacy,
Property Tax Relief & Revenue

Wednesday, April 22, 2009, 10 am, Room 411 South

I want to thank the committee for considering this legislation which will help make sure that patients in Wisconsin's health care facilities receive the best possible care. One of the ways to accomplish that goal is the make sure that we have enough nurses to meet the needs of these patients.

Wisconsin is already facing a shortage of nurses and the shortage will continue to increase unless we take steps to retain the qualified nurses we have and to educate and recruit new nurses.

One of those steps toward retaining nurses is to ban mandatory overtime. Among the leading reasons why nurses leave the profession is stress, burnout and clinical errors that are aggravated by mandated overtime.

Mandatory overtime leads us into a vicious downward cycle. Excessive hours and fatigue reduce morale, which in turn contributes to job burnout. Job burnout reduces staff retention. Job loss creates more nursing vacancies, forcing the remaining nurses to pick up the load by working more overtime.

By banning mandatory overtime, we begin to break that cycle. As a result, the nurses who are working today will be more likely to stay in nursing. New nursing graduates will know that there will be decent working conditions that will allow them to practice nursing at the highest level.

We all recognize that nurses who must work 16 hours straight become exhausted and cannot do their jobs adequately.

A study in the national journal *Health Affairs* found that nurses who worked shifts of 12.5 hours or more were three times more likely to commit an error than nurses who worked a standard shift of 8.5 hours or less.

This study confirms research by the Wisconsin Federation of Nurses and Health Professionals which found that fatigue can lead to clinical errors in administrating medications and lead to impaired ability to detect critical changes in a patient's condition.

For these same reasons, laws limit the hours that long-haul truckers, airline pilots, flight attendants and other transportation workers can work. It is well recognized that alertness is critical to the safe performance of their jobs.

It's surprising that nurses and nursing assistants - who make dozens of life and death decisions each day - can be mandated to work double shifts without planning or warning.

This bill prohibits health care institutions, hospitals, nursing homes and other facilities from requiring health care workers to work overtime.

The prohibitions in the bill do not apply:

1) If the health care worker consents to working overtime;

2) If the health care worker's continued presence through the completion of an ongoing medical or surgical procedure is essential to the health and safety of the patient.

Recognizing that under some circumstance mandatory overtime may be necessary, the bill allows a health care facility to mandate overtime in cases of unforeseeable emergency, **if** the health care facility first exhausts all other options.

However, the bill specifics that an "unforeseeable emergency" does not include a situation in which the health care facility has inadequate staff due to chronic short-staffing or other foreseeable causes.

The bill also prohibits a facility from discharging or discriminating against a worker who refuses to work mandatory overtime or files a complaint related to mandated overtime.

This bill is necessary and significant because of the number of health care workers it will affect.

Currently 15 states prohibit the use of mandatory overtime for nurses. Those states are Connecticut, Maine, Maryland, New Jersey, New Hampshire, New York, Oregon, Pennsylvania, Washington West Virginia, California, Missouri Texas and our two closest neighbors -- Illinois and Minnesota.

It is time for Wisconsin to join with those 15 other states that have already acted to restrict mandatory overtime in hospital and other health care settings.

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TO: Chairperson Jon Erpenbach and Members of the Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Gina Dennik-Champion, MSN, RN, MSHA
Executive Director, Wisconsin Nurses Association

DATE: April 22, 2009

RE: Support for SB 108 – Relating to Mandatory Overtime Hours and On-call Time Worked by Health Care Workers and Providing Penalties

Good morning Chairperson Erpenbach and members of the Senate Health, Health Insurance, Privacy Property Tax Relief, and Revenue Committee. My name is Gina Dennik-Champion, I am a registered nurse and I am here today representing the Wisconsin Nurses Association (WNA). WNA is the professional association for all RNs in Wisconsin. As a professional nurse association, WNA promotes the goal of recognizing the registered nurse an essential provider in all practice settings through education, research, workforce advocacy, legislation, and regulation. WNA promotes the nursing profession and the full utilization of registered nurse services so that patient care is delivered safely and competently.

Thank you for allowing me the opportunity to share WNA's support of SB 108 and the companion bill AB 152 – Relating to Mandatory Overtime Hours and On-call Time Worked by Health Care Workers and Providing Penalties. WNA extends appreciation to Senator Judy Robson and Representative Sandy Pasch for sponsoring this legislation and the members of this committee who are in support of these legislative proposals.

Mandatory overtime is a difficult problem for RNs and health care facilities. Overtime is defined as the hours worked in excess of an agreed upon, predetermined, regularly scheduled full or part time work schedule, as determined by established work scheduling practices, policies or procedures. Because of inadequate RN staffing, employers have used mandatory overtime to staff facilities. Concern for the long term effects of overtime include impact on the RN's health, as well as the potential for errors or near misses from fatigue and diminished quality of care provided. Research on RN staffing conducted by Ann Rogers RN, PhD and her colleagues in 2004 reported that risks of making an error are significantly increased when work shifts are longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week. (Rogers A, et al. The Working Hours of Hospital Staff Nurses and Patient Safety. *Health Affairs* 2004;23(4):202-12.

WNA's position for approximately ten years has been in support of banning mandatory overtime. Our interest in addressing overtime work has increased given the research on nurse fatigue, impact on patient safety and nurse overall health status. In addition, our support heightened

when we learned about an unintentional medical error committed by a very fatigued RN that resulted in the death of her patient. This nurse was terminated from her job and faced sanctions by the Board of Nursing. What also occurred and sent shivers throughout the nursing community was the fact that she was brought up on criminal felony charges for her unintentional medical error. In addition, the Office of the Inspector General notified this RN that she was prohibited from providing nursing care in any federally funded government agency for five years.

Although the scheduled hours worked by this Wisconsin RN were voluntary, the dangers of working fatigued, either forced or voluntary, present significant ramifications for patient safety, quality of care and the ability to practice nursing. WNA concurs with the position taken by our national professional association, American Nurses Association (ANA), "...that regardless of the number of hours worked, each registered nurse has an ethical responsibility to carefully consider his/her level of fatigue when deciding to accept any assignment extending beyond the regularly scheduled work day or week, including mandatory or voluntary overtime assignment" (ANA on the world wide web at http://nursingworld.org/MainMenuCategories/ANAPoliticalPower/Federal/Issues.aspx ,2009).

SB 108 prohibits the use of mandatory overtime and on-call time as a means of addressing nurse staffing shortages on a regular basis. This legislation promotes patient safety and quality of care. These two factors are what patients, insurers and government agencies expect and pay for. SB 108 gives nurses the opportunity to say "no" to mandatory overtime and provide protection from retaliation by the employer. Saying "no" to mandatory overtime should be viewed not as abandoning the organization's cultural attitude of being a "dedicated employee," but rather, an appreciation for a professional who has determined that her/his level of fatigue could compromise patient safety and nurse health. The prohibition on mandatory overtime regulations imposed on the airline and trucking industry, as well as the rules imposed on teaching hospitals to restrict the hours of medical residents, were developed to support public safety. WNA would like to see the same expectations placed on employers of direct care nursing staff. This legislation recognizes the value of having an alert, well-rested professional RN at the bedside and deters health care organizations from compromising patient safety.

Again, thank you to Senator Judy Robson and Representative Pasch for sponsoring this legislation. Thank you for the opportunity to present WNA's support of SB 108 and the companion bill AB 152.

WMC
WISCONSIN'S BUSINESS VOICE

To:	Chairperson Jon Erpenbach Members of the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
From:	R.J. Pirlot, Director, Legislative Relations
Date:	April 22, 2009
Subject:	**Opposition to Senate Bill 108**, relating to mandatory overtime hours and on-call time worked by healthcare workers.

Senate Bill (SB) 108 would prohibit a healthcare facility from requiring an employee who is involved in providing direct healthcare services for patients, and who is paid an hourly wage, to work for more than a regularly-scheduled daily work shift that has been determined and agreed to before the performance of the overtime work or to be on "on-call" time. The prohibition would not apply if (1) the employee consents or volunteers to work overtime or to being on on-call time, (2) the employee's presence through the completion of an ongoing medical or surgical procedure in which the employee is actively engaged is essential to the health and safety of a patient, (3) there is an "unforeseeable emergency," or (4) there is an unanticipated or unavoidable disaster that substantially affects or increases the need for healthcare workers. WMC opposes SB 108.

Wisconsin Manufacturers & Commerce (WMC) is the largest representative of Wisconsin businesses with our members employing approximately one-quarter of the state's private-sector workforce. Wisconsin businesses understand that in order to attract and retain good, productive employees, Wisconsin businesses need to ensure their employees have access to high-quality, affordable health care. Employees with access to good health care tend to be more productive and have lower rates of absenteeism than employees without. As such, WMC is keenly interested in and has a long history of promoting patient safety, healthcare quality, and affordable health care.

SB 108 Would Compromise Patient Safety

Mandatory overtime is a little-used, though needed, strategy to ensure healthcare facilities are adequately staffed and able to provide continued, suitable care for patients. WMC is concerned that enactment of SB 108 would place patients at risk by undermining the ability of healthcare facilities to maintain appropriate staffing levels.

Proponents of SB 108 argue SB 108 contains exceptions adequate to ensure staffing levels can be maintained, on a mandatory basis, should circumstances dictate. For example, under SB 108, mandatory overtime would not be prohibited if there is an "unanticipated or unavoidable disaster that substantially affects or increases the need for health care workers." Unfortunately, these one-size-fits-all exceptions are inadequate, poorly defined, and would invite litigation.

SB 108 is Really an Attempt to Settle a Labor-Management Issue

Proponents of SB 108 typically argue the legislation is about promoting patient safety by preventing fatigued healthcare workers from providing patient care. The language of SB 108 indicates otherwise. SB 108 would *still* allow healthcare workers to work overtime, should they

volunteer to do so. SB 108 would also allow healthcare workers to voluntarily work a shift in a different facility or different line of work, and then work a shift in a covered facility. From a patient's perspective, if a healthcare worker is fatigued, it makes little difference whether the worker is working long hours on a mandatory or voluntary basis, or due to other reasons, such as working a second job.

What SB 108 actually appears to be intent on is settling, by state fiat, an issue regarding which employers and their employees typically negotiate or bargain.

Wisconsin Healthcare Facilities are National Leaders in Patient Safety, Quality

Wisconsin healthcare facilities, in particular Wisconsin hospitals, are national leaders in promoting patient safety and quality improvement. For example, the Wisconsin Hospital Association's *CheckPoint* initiative, in which 128 hospitals voluntarily participate, collects and disseminates easy-to-understand patient safety and quality indicators on a host of issues, such as heart attacks, pneumonia, error prevention and surgical infection prevention. A second example is the Wisconsin Collaborative for Healthcare Quality (WCHQ), a consortium of healthcare organizations and purchasers which collects and reports healthcare quality data, in a consumer-oriented format, on subjects such as patient safety, effectiveness of care, and system efficiency Both *CheckPoint* and the WCHQ are held up as national models to be emulated.

WMC supports and promotes *CheckPoint* and the WCHQ.

WMC respectfully requests you oppose SB 108.

To: Members of the Senate Committee on Health Care and Health Care Reform

From: Tim Gengler, RN, MSN, CAN,
VP Nursing/Chief Nursing Officer (CNO)
Aspirus Wausau hospital (AWH)

Date: April 22, 2009

Subject: Written Testimony in Opposition to Senate Bill 108 related to Mandatory Overtime

As a health care worker, I want to respectfully submit my written testimony in opposition to Senate Bill 108 related to mandatory overtime. I believe this bill will have a significant negative impact on patient care. I have been a nurse who has practiced in the acute care hospital setting for thirty-three years. In my current role as CNO at Aspirus Wausau Hospital, I am charged with insuring safe and quality care to the patients we serve. This can only be accomplished through competent professional nurses. Therefore, it is my responsibility to make sure that we have adequate staff who are prepared to carry out our mission.

A team of fourteen AWH staff that included bedside nurses and management, met with Senator Russ Decker and Representative Donna Seidel on March 13 to discuss possible ramifications should this bill be passed. The legislators heard several real life stories about the need for flexibility in staffing to accommodate the countless scenarios to safely care for the patients we serve.

As a policy, AWH does not utilize mandatory overtime. Responding to unpredictable healthcare needs requires flexibility around the clock. We use a variety of supplemental staffing resources to insure quality patient care. Being a Magnet Hospital, our nurses take great pride in their profession and told the legislators MOT legislation diminishes that professionalism and is not required. Our staffing policies cover most of the unpredictable events, but cannot cover all of them. Our staff recognize that and will do what is necessary to protect our patients. They will work beyond their normally scheduled shift if it is the only remaining option. They do not compromise patient safety and do not see stopping care as a possibility.

AWH has engaged our staff in developing policies to prevent fatigue. We limit scheduled hours per shift, promote breaks and lunch periods, and allow adequate time between shifts to prevent fatigue. That said, we cannot control voluntary fatigue from some staff who choose to work other jobs or not rest before coming to work. SB 108 is not viable if it does not address voluntary fatigue that can contribute to unsafe conditions, and therefore must equally address voluntary and involuntary fatigue.

The definition of "disaster" and "emergency" are not sufficient to cover local events that could create an emergent staffing need for hospitals in different communities. For

example, our nurses relayed several actual events to our legislators that required immediate staff response to ensure safe patient care:

- Several laboring obstetric patients have presented in a very short period of time
- A recent bus load of children exposed to toxic chemicals required rapid response for immediate care
- Unpredicted life or death emergent surgeries present periodically
- Unanticipated staff absences due to bad weather or last minute sick call-in's create acute shortages until relief can be brought in
- Unpredicted spikes in census from unscheduled emergency room or clinic direct admissions require enough staff to meet even the most basic needs

These events are unpredictable and are only a sampling of what can occur. Hospitals must be fiscally responsible to our communities. We all understand our accountability to be good stewards of our patients' and tax payers dollars during this time of economic crisis. We have created supplemental staffing practices to meet most needs, however, could never predict to cover them all and continue to provide affordable patient care.

Again, we have not required MOT at AWH. Our staff take pride in their work and will take care of our patients and their own profession. Legislating a ban on MOT is not required in central or north central Wisconsin. If there are a few hospitals in our state that are the reason for the creation of this bill, then this issue should be addressed at those facilities and not at the expense of all of the hospitals and patients in our state. Unfortunately, SB 108 mandates a one-size-fits all approach.

While mandatory overtime would be an option of last resort, it should be an option if patient care needs demand it. Please do not put our patients safety at risk and take away a last resort. I respectfully ask you to oppose SB 108.

Thank you.

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Testimony of Allison Sorg, RN

Senate Committee on Health

April 22, 2009

SB108: Prohibition of Mandatory Overtime for Health Care Workers

My name is Allison Sorg. I've been a nurse at Meriter Hospital for 4 years and have worked in labor and delivery and am now in the Perinatal Float Pool, assigned to labor patients, postpartum mothers and their babies, mothers who have not yet delivered and may be ill or on bedrest, post-surgical mothers and their babies, and the Neonatal Intensive Care Unit. Despite disparaging remarks from Rep. Vukimir in the Assembly about float and pool staff, we are a well-trained group of nurses and a tool in the box for hospitals to cover their shifts.

Since starting in labor and delivery 3 years ago, I have been mandated 7 times, usually for a partial shift, but occasionally for an entire 8 hours. I've also volunteered when I've felt rested enough to work longer and when I knew my obligations the following day were such that I could get by on very little sleep.

I've been mandated on days I've had sick children at home, leaving my husband to care for them and call in sick to his job the following morning. Once I was mandated when my husband had to leave town for a business trip, leaving us scrambling at 10 p.m. to find a grandparent to come from an hour away at 5:30 a.m. the following day. Another time I was mandated when I was caring for a sick pet that needed IV medications only I was trained and capable to give. She later lost her eye. I'll never know if the omitted medications caused that loss.

What is also unsafe is when I am mandated after 8 hours of working the PM shift and I'm expected to work the next day. I go to sleep hours later than usual, if at all. My children get up at the same time in the morning meaning I get less sleep. I am then expected to return for next shift that afternoon at 3 p.m. The next day I feel exhausted and less attentive. I double and triple check everything I do. One manager told me if I am that tired, I should call in sick and use my earned time off to make up the shortfall on my paycheck!

Nursing is facing critical shortages in the near future as older nurses retire and others leave the workforce. But right now, there are student nurses on our floors saying that when they graduate, they can't get a job at our hospital because we don't have any positions open. That's hard to hear when earlier that week, 4 nurses were mandated in a single night. Hospitals say there is a nursing shortage, and to some extent that is true. There is a shortage of nurses who want to work at the bedside knowing they are likely to be mandated to stay overtime and potentially lose their licenses, their livelihood, or injure or kill a patient through an error.

UW Hospital no longer mandates and made up for the extra hours for which they needed nurses by adding more nursing staff. Meriter increased staff last year in a few units. Their mandates on those units went to almost none. Areas where minimal or no nurses were added, including the Birthing Center, showed no change in the number of mandates. Last year, we had 17 or 18 maternity leaves to cover, including all 3 nurses on the same 12 hour weekend shift. No nurses were added to cover those shortages despite 9 months of notice that these leaves were coming. Leaving the option to mandate overtime up to the hospitals is not working. We need this law to prevent this from happening.

Allison Sorg, RN
4 years, Meriter Hospital
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Wisconsin Federation of Nurses & Health Professionals AFT, AFL-CIO
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Ban Mandatory Overtime for Nurses and Health Care Professionals
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
Support for SB 108
Wednesday, April 22, 2009

Testimony of Stephanie Bloomingdale
Director of Public Policy, Wisconsin Federation of Nurses and Healthcare Professionals

My name is Stephanie Bloomingdale and I am here on behalf of the Wisconsin Federation of Nurses and Health Professionals (WFNHP). WFNHP is a labor union that represents more than 3,000 nurses and healthcare professionals throughout Wisconsin. I am here today to urge your support of SB108 which would ban the dangerous practice of forcing nurses and healthcare workers to work past the end of their shift except for cases of unforeseen emergencies such as a major disaster.

The legislature now has the opportunity to make hospitals safer for patients in Wisconsin. Hospitals that force nurses to work beyond the end of their shift put patients at risk and drive nurses out of bed-side nursing. Nurses who are mandated to work overtime, sometimes for up to 16 hours in a row, are forced to put patient safety in jeopardy. By passing this legislation, the legislature will make hospitals safer for patients and better for nurses.

In an attempt to cut costs and maximize profits hospitals routinely force nurses to work mandatory overtime to care for patients. Nurses provide the majority of hands-on care for patients and therefore, are one of the largest cost centers in hospitals. Over the past decade hospitals, in the race to compete with each other and build more hospitals, have slimmed nursing staff and relied on mandatory overtime to make up the difference. Using mandatory overtime to staff hospitals may result in short term savings – but actually results in huge needless expenditures, both in terms of patient safety and nurse retention.

Mandatory overtime exists in Wisconsin. While it is true that not all hospitals engage in the risky policy of forcing nurses to work mandatory overtime, many still do. According to nurses surveyed by the WFNHP, 42% have been forced to work overtime at least once a month, with 12% mandated once a week.[1] Mandatory overtime is sometimes called required overtime, essential overtime, or compassionate overtime. Some hospital administrators have gone so far as to ask their managers to remove the word "mandatory" from their vocabulary, instead asking them to call it "essential" or "required" overtime. Regardless of the label attached, it is still the practice of forcing a nurse to work beyond the end of her shift.

Staffing and ensuring quality patient care are the same. Some hospital administrators have tried to separate the idea of staffing from delivering quality care in an attempt to defend mandatory overtime. Let's not be confused – "staffing" is "ensuring quality patient care."

Fatigued nurses are more likely to make mistakes. Everyone knows that you can't be on the top of your game when you are exhausted. So why would nurses and healthcare workers be any different. Fatigued nurses may miss subtle changes in a patient's condition or even make mistakes that could potentially harm the patient. Studies show that after 17–19 hours without sleep, the performance of subjects was equivalent or worse than at a blood alcohol level of 0.05 percent. After 24 hours of sustained wakefulness, the impairment was equivalent to that caused by a blood alcohol concentration of 0.10 percent.[2]

What do the nurses say about the effects of mandatory overtime on patient safety? Hospitals do not share information about mandatory overtime rates or error rates. So we have to rely on what the nurses tell us. Nurses agree that quality care suffers when nurses are required to work forced overtime. In fact, 96% said that quality suffers, and 56% said quality suffers a great deal, and 43% of nurses said they were aware of errors in care that have occurred as a result of nurse fatigue.[1] Over 500 nurses listed examples of errors. The overwhelming number of examples centered on medication errors. The errors reported by the nurses included giving the wrong medication, the wrong dosages, administering drugs at the wrong time and to the wrong patients. The other concerns cited were examples of nurses falling asleep at work or while driving home.[1]

What is it like to be a nurse forced to work 16 hours in a row? Imagine an oncology nurse who works a night shift from 11:00 pm until 7:30 am. All night long she delivers chemotherapy and care for patients with complex medical needs, many with multiple IV's. At 6:00 in the morning her supervisor tells her she can't go home and she needs to cover the next shift. She can hardly keep her eyes open and says that she was very afraid of making a mistake. She was afraid for her patients. This was not an emergency. The schedule had been out for four weeks without a nurse scheduled for that shift.

Mistakes cost lives. The Institute of Medicine estimates that 98,000 people die from preventable medical mistakes in the U.S. every year.[3] Medication errors are among the most common medical error, harming at least 1.5 million people every year.[4]

Mistakes cost money. A study by HealthGrades, estimates that patient safety incidents cost the federal Medicare program $8.8 billion and has resulted in 238,337 potentially preventable deaths during 2004 through 20006.[5] The extra medical cost of treating drug related injuries occurring in hospitals alone conservatively amount to $3.5 billion a year, and this estimate does not take into account lost wages and productivity.[4]

MOT forces nurses out of the profession. When a nurse is told she must work mandatory overtime she is forced to choose between her license and her job. Often she must also choose between her family and her patients. Working in an environment where nurses don't know if they will be able to leave after their shift or whether their fatigue may result in severe medical errors is difficult and stressful for nurses. Some choose to leave bedside nursing altogether because of the untenable working conditions. In fact, 30% of nurses who were not eligible to retire were considering leaving the profession due to poor working conditions including mandatory overtime.[1]

Hiring and training new nurses is expensive. The cost to replace a medical/surgical nurse averages about $46,000 and replacing a critical care nurse costs an average of $64,000.[6]

Other states have passed bills to ban mandatory overtime. Since 2000, 15 states have either banned mandatory overtime or have passed laws restricting its use in healthcare facilities. (The 15 states include: California, Connecticut, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, Washington and West Virginia.) Wisconsin patients deserve the same safety protections afforded to the patients in these other 15 states.

Hospitals can eliminate forced overtime AND deliver quality care to patients. In fact, not all Wisconsin hospitals choose to engage in the risky practice of forcing nurses to work mandatory overtime. It is the responsibility of management to ensure proper staffing to meet the needs of patients. Responsible staffing requires planning and forward thinking. It should not be a surprise to hospital administrators that patient census is likely to change and should therefore be taken into consideration when doing initial staffing grids. The number one solution is hiring enough nurses in the first place, after that hospitals can utilize internal pool and external agencies to fill in slots as necessary. The bottom line is that Wisconsin patients deserve safe patient care and that quality care is jeopardized when nurses and healthcare workers are forced to work overtime.

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1 Wisconsin Federation of Nurses and Health Professionals; 2008 Survey of Milwaukee-area nurses.

2 Williamson, AM and Feyer,AM. "Moderate Sleep Deprivation Produces Impairments in Cognitive and Motor Performance Equivalent to Legally Prescribed Levels of Alcohol Intoxication," Occupational and Environmental Medicine; October 2000; 57(10): 649-655.

3 "To Err is Human," Institute of Medicine of the National Academies; November 1999.

4 "Preventing medication errors," Institute of Medicine committee on identifying and preventing medication errors; July 2006.

5 HealthGrades; Fifth annual patient safety in America hospitals study; April 8, 2008.

6 Voluntary Hospital Association.

To: Honorable Members of the Senate Committee

Date: April 22, 2009

Re: Testimony in Opposition to Senate Bill 108

Thank you for the opportunity to provide this testimony. My name is Kristi Hund. I am a nurse of 31 years. In my career as a critical care staff nurse I experienced being mandated to work additional hours on multiple occasions and as a nurse administrator I am responsible for the challenge of staffing a small critical access hospital with a fluctuating census and an unpredictable level of acuity. I feel qualified to say I understand both sides of this issue. It is with this understanding that I am sharing my opposition to Senate Bill 108.

Stoughton Hospital's mission is to provide safe, quality care in a personalized manner. The leadership in our organization takes patient safety very seriously. One of the most important ways we assure patient safety is by providing adequate numbers of nurses with the appropriate skills and experience to take care of our patients. We staff for our average daily census of 12 but rarely if ever do we start and end a shift with the same 12 patients. We may start the day with six patients and end it with eighteen. An unpredictable census and acuity level is a daily reality for us. Staffing flexibility is a daily need for us.

We expend numerous resources cross training staff to multiple units and building our per diem pool. Stoughton Hospital employs over 100 nurses; most of them part time in an effort to have maximum scheduling flexibility. Like most hospitals our size, we do not have the luxury of float pools or multiple units to shift staff from a less busy unit to a busier one. Having reviewed the evidence regarding the relationship between the numbers of hours worked and the incidence of medical errors, we do not use overtime as a staffing practice.

There are many occasions when we ask staff if anyone is willing to pick up hours over their scheduled shifts and generally someone expresses interest because they want additional money or want to be helpful. This occurs mostly when the census spikes for a prolonged period of time or when illness passes through the staff. Senate Bill 108 addresses disasters but in our experience that is not the time we may have needed to mandate staff. Stoughton was hit by a tornado several years ago and our nurses volunteered to work more hours than we needed. In snowstorms these same nurses pack a bag, arrive early and sleep over if necessary to voluntarily assure our patients are cared for. It is the smaller yet crucial unanticipated need that provides our greatest challenge.

I want to share an example of how we are likely to be adversely affected by the limitations Senate Bill 108 would place on our organization. Stoughton Hospital has a ten-bed geriatric psychiatry unit caring for patients with a variety of psychiatric diagnosis as well as patients who present with behavioral issues associated with advanced Alzheimer's disease. Our psychiatric nurses are highly specialized in the medication

routines, therapeutic milieu and specialized mental and physical health needs of this elderly population. The unit is staffed with an RN and an LPN each shift along with nursing assistants. One Saturday morning our nurse called in sick with an affliction that affected numerous nurses on the staff. After an hour of trying every available nurse who was oriented to this unit to no avail, the supervisor called me. If we were unable to provide a nurse for one or two ICU patients we would be forced to arrange for their transfer to Madison. We could not however transfer 10 elderly psychiatric patients to Madison between 6 and 7 am. As happens, just as we would have had to ask the night nurse to stay, our Med/Surg manager who used to manage the psych unit agreed to come in and work as a staff nurse on her day off. We go to great lengths to avoid requiring nurses to work beyond their shift and are successful as we have one shift of mandatory overtime in eight years.

The reality is as a small hospital we cannot afford to staff at the level that prepares us for any staffing emergencies that may occur. While doing so would make our lives much easier, it would not be fiscally responsible. It would drive up the cost of healthcare even further and we are constantly reminded of our responsibility to our community to control the escalating costs of providing patient care. Our consumers are rightly demanding we make healthcare more affordable not less so.

I want to thank you for your attempt to support nursing and patient care. I believe this bill falls short of addressing the true issue of fatigue and provides unnecessary constraints to providing safe staffing levels for crisis staffing situations. This bill does not address non mandatory overtime which is as much a contributor to worker fatigue. It does not recognize that responding to unpredictable staffing needs requires flexibility. We need to be able to ask nurses to voluntarily work above their scheduled shifts. The unpredictable nature of our business demands this. Patients in hospitals today are very ill. They expect and deserve nurses available to take care of them. Their safety depends on this.

I want you to know there is nothing in it for Stoughton Hospital to disregard patient safety by forcing nurses to work overtime. If we had a sub standard safety record our patients would seek another hospital. Mandatory overtime is a poor staffing solution and if we use it our nurses will seek employment in one of the excellent nearby hospitals. When I chose nursing as a career I did so knowing that sometimes I would need to place the needs of patients before my own. I am asking you to put the needs of patients first and vote against Senate Bill 108 as currently written.

Stoughton Hospital promises you we take safe care of our patients and our nurses. I would ask that you consider focusing your support on resources to expand the number of nurse educators and consider providing other measures to assure an adequate nursing workforce in the future. This is the area I believe we really need your help.

Kristi Hund, VP Patient Services/CNO Stoughton Hospital
416 Homme Court
Stoughton, WI 53589

MINISTRY HEALTH CARE

Assembly Bill 152/Senate Bill 108 (ban mandatory overtime)

Ministry Health Care position: Oppose

Ministry Health Care registered against the legislation because the current language does not allow for unforeseen circumstances, which may include high patient census, multi-case trauma, ill workforce, inclement weather, and more.

Ministry Health Care does not use mandatory overtime as a standard business practice. It is only used in emergencies, to avoid understaffing which could compromise patient quality and safety. This happens only on rare occasions. As written, the legislation would not permit even one hour of overtime.

Ministry Health Care supports, and provided input in development of the Wisconsin Hospital Association guiding principles to prevent worker fatigue. This includes practices allowing adequate time off between scheduled shifts, and minimizing prolonged shifts. We believe these principles are a better strategy to prevent fatigue among health care professionals.

About Ministry Health Care: We earn trust by working together as One Ministry to keep PATIENTS FIRST in everything we do. This is our promise to our patients, to each other, and to the communities we serve. Founded 126 years ago by the Sisters of the Sorrowful Mother, Ministry Health Care is an integrated, mission-driven health care system serving primarily rural and underserved communities across Wisconsin and into Minnesota.

MINISTRY HEALTH CARE
Sponsored by Sisters of the Sorrowful Mother

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Testimony Opposing Senate Bill 108

I am here today to testify in opposition to Senate Bill 108 on behalf of the Wisconsin Organization of Nurse Executives (W-ONE) and Columbus Community Hospital. I am the Secretary of the Board of Directors for W-ONE and Vice-President of Patient Care Services for Columbus Community Hospital.

W-ONE represents over 250 nurse administrators, managers and faculty members of Wisconsin's hospitals, health care agencies and schools of nursing. Columbus Community Hospital (CCH) is a rural community critical access hospital (25 beds) that employs approximately 120 (69.6 FTEs) clinical and lab staff. W-ONE and CCH oppose Senate Bill 108 because health care organizations currently maintain effective supplemental staffing resources and rarely utilize mandatory overtime (MOT). As a Nurse Executive, I am opposed to this bill for the following reasons:

- We currently use PRN staff and agency staff when necessary
- We staff each shift based on MESH, an acuity system that is an indicator for the number of staff necessary from shift to shift based on patient acuity
- We staff on what is an average daily census, however, health care is not predictable – acuity may suddenly change, unexpected admissions or emergency surgeries may occur, and trauma /emergency care may be required at any time.
- Unforeseeable emergencies are not just major disasters as defined in this bill. Not allowing hospitals the ability to call in additional help during these times will impact the care of our patients and may put their healthcare needs and life in jeopardy.
- Critical Access Hospitals do not have the same number of human resources that a large organization may have and while we may be staffed adequately the majority of time, based on our average activities, a sudden unanticipated change in volume or in acuity may stress our current ability to provide safe and adequate care. Having the ability to tap into staff resources available to work additional hours may be required to cover the emergency to safely care for our patients.
- Without this flexibility, patient care would be compromised or the need to divert elsewhere would put the patient at great risk as well as move the problem to another hospital. In addition, due to EMTALA requirements, diverting may not be possible due to the patient's condition.

An example of how this bill would impact our organization occurred recently. One of our Lab Medical Licensed Technicians became ill at the beginning of his shift, requiring hospitalization and surgery. This was an unexpected situation in which we needed to provide a replacement in order to provide lab services to our patients. This would not have been an unforeseen emergency as defined in the bill, however, for our hospital, this was an unforeseen emergency. Lab personnel who were not previously scheduled were asked of their willingness to stay until another staff was willing to pick up the additional shift. Had not staff volunteered, it would have been necessary to mandate. This is a very rare occurrence and would only be used in an unforeseen situation until additional staff could be contacted. A law prohibiting our ability to ask for employees to replace staff at times like this will increase the risk and safety to our patients.

W-ONE has recently reviewed the concepts of scheduling practices and fatigue factors for nurses of which copies will be provided to Committee Members. CCH has included education on fatigue as part of our Employee Skills Fair. Issues of fatigue continue to be addressed by increasing staff awareness on the need for adequate rest periods, appropriate assignments, number of hours worked, personal lifestyle issues, and time off between scheduled shifts.

In closing I believe organizations have taken proactive approaches to address issues surrounding staffing and to utilize supplemental staff when the need arises. As noted previously, healthcare is unpredictable. Mandating a ban on mandatory overtime prevents the ability for healthcare organizations to adjust staffing in the unanticipated situations that require additional staff resources to provide safe and accessible care to our patients. I appreciate the opportunity to testify on behalf of W-ONE and CCH and to respond to what is proposed under Senate Bill 108.

Peg Haggerty, RN, EdD
Vice President Patient Care Services, CCH
Secretary, W-ONE

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Position Statement of the Wisconsin Organization of Nurse Executives
Scheduling Practices
January 28, 2009
March 26, 2009 Updated

The Wisconsin Organization of Nurse Executives (W-ONE) recognizes that health care agencies have invested in effective measures to increase staffing levels in response to patient need. Health care facilities utilize a variety of supplemental staffing resources including internal float nurses, local agency staff, call and per diem programs and long term travel nurses. For these and other reasons, W-ONE opposes any legislation on mandatory overtime.

An adequate supply of nurses is currently available in Wisconsin communities and their healthcare facilities. At the current time no counties are reporting acute shortages of nurses and very few graduates are required to relocate to find employment. Mandatory overtime is not being used for routine staffing needs.

Restrictive staffing rules may result in limiting access to emergent care. Hospitals do not directly control patient volumes or acuity levels. Staffing needs are unpredictable and can change very quickly. Variations are most often seen in Labor and Delivery units, Emergency Departments and Medical units. Scheduling restrictions may limit the amount of legally available staff and unintentionally decrease availability of some of these essential unpredictable service needs. These staffing limitations may reduce patient access to critical hospital services.

W-ONE also recognizes that Healthcare professional fatigue is an emerging concern in many settings and is considered when increases in census or acuity require unexpected increases in the planned staffing. Many factors may contribute to fatigue however it is frequently attributed to excessive work hours. Excessive work hours either mandated or voluntary, contribute to a variety of unsafe conditions. Therefore any legislation which addresses mandatory limits on work hours, should also address hours voluntarily worked and hours worked by one individual at several organizations. Any use of overtime in emergency staffing situations must include an assessment of the healthcare provider's fitness to continue providing safe care.

It is W-ONE's position that:

- responsible, planned programs to address unpredicted surges in capacity can and should be monitored and regulated by the professions involved;
- that mandatory overtime is not used as a routine staffing mechanism in health care facilities; and
- that no legislation is necessary to address mandatory overtime.

W-ONE is committed to providing leadership to address the quality and safety of patient care in our organizations. To do less would be to abdicate our responsibility to safely staff healthcare organizations.

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Strategies for Addressing Health Care Worker Fatigue, 2008, The Joint Commission on Accreditation of Healthcare Organizations.

White Paper:
Nurse Scheduling and Fatigue in the Acute Care 24 Hour Setting

Prepared at the request of
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by

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White Paper:
Nurse Scheduling and Fatigue in the Acute Care 24 Hour Setting

The nursing profession, which many consider vital to patient safety and care in the hospital, is examining the relationship between hours spent at the bedside without sufficient rest to the quality of care provided. Currently nurses in acute care facilities work long hours and overtime ranging from a few hours to full shifts; they do so either by choice or as a condition of employment. Missing breaks and lunches during these long stretches of work occurs regularly (Rogers, Hwang & Scott, 2004a; Scott, Rogers, Hwang & Zhange, 2006; Trinkoff, Geiger-Brown, Lispcomb & Mutaneer, 2006). Long work hours can and often do result in poorer patient outcomes (IOM, 2004).

A number of social phenomena are associated with nurses working long hours. Patients in acute care facilities must be cared for by nurses around the clock. Hospitalized patients are more acutely ill than at any other time in history requiring lower nurse to patient ratio. A nursing shortage has been well documented, leaving vacant nursing positions unfilled. Fewer persons are entering nursing and often leave at a younger age than other professions. Health care costs continue to increase and systems are continually challenged to manage budgets, including management of nursing budgets (Honor Society of Nursing, 2001). Other professions have set limits on the number of hours that are worked in a twenty-four hour period without rest. The medical profession restricts the length of their time residents may remain on duty (IOM, 2004). This change has had an impact on other professionals, namely attending physicians and nurses, further heightening the critical need for nurses to function safely and productively.

Researchers consistently identify a relationship between hours worked, nurse fatigue, and errors; with error rates doubling at 12 hours of work and tripling at 16 hours (IOM, 2004; Rogers, Hwang, Scott, Aiken, & Dinges, 2004b). Fatigue is often characterized by a decreased ability to complete work and a subjective complaint of feeling tired. Inadequate rest, sleep loss, and shift work schedules often contribute to fatigue (IOM, 2004). Fatigue has been reported to produce slowed reaction time, omission errors, impaired problem-solving abilities and attention lapses (Van-Griever & Meijman, 1987). Furthermore, fatigue may diminish productivity and lead to errors and accidents (IOM).

Numerous factors potentially affect work schedules and fatigue. Among these factors are staffing schedules, number of full and part-time personnel on unit, lifestyle decisions nurses make related to family and sleep, use of agency nurses, patient acuity, type of unit (intensive care unit, specialty unit, general unit), teaching or community hospital, personal preferences for shift worked and management support for staffing schedules. Recommendations to combat fatigue and decrease the potential for errors have been proposed by the Institute of Medicine (IOM) in "Keeping Patients Safe: Transforming the Work Environment of Nurses". The IOM states that "...to reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24 hour period and in excess of 60 hours per 7 day period" (2004, p. 237).

In general, studies of nursing work schedules have been researched using descriptive or correlation designs resulting in conclusions that are associational rather than causative. Across these studies (see Evidence Tables I & II) there is agreement that working over 12 hours, working overtime, and inadequate rest (i.e. less than 8 hours in between shifts) are associated with higher error rates. This IOM recommendation, related to limiting number of hours worked per week is based on writing of Jha, Duncan, and Bates and a 2002 descriptive study of American Nurses Association nurses (Rogers et al., 2004b). This conclusion was drawn based on how other safety industries have responded to work fatigue and the above mentioned study. In this study, Rogers and colleagues (2004b) did find that working greater than 40 hours per week increased errors, but did not delineate what type of shifts were worked to equal greater than 40 hours (i.e. four twelve-hour shifts, four sixteen-hour shifts, etc..). No other studies were found in which number of hours worked per week was evaluated in nurses. There is some suggestion that longer work hours are particularly fatiguing for nurses over 40 years old or nurses working the night shift (Kunert, King & Kolkhorst, 2007; Muecke, 2005). There is some evidence that persons working 12 hours rather than 8 hours with longer rest periods (i.e., greater number of days off between tours of duty) actually experienced less fatigue (Gillespie & Curzio, 1996).

Implementation of the IOM recommendation would limit the capacity for health care systems to generate and test alternative methods of scheduling nurse work. Upon examination the recommendation to limit nursing to a 60 hour work week has been inadequately validated by research at this point. Many hospitals have been able to develop creative staffing solutions aimed at improving staffing and attending to the preference of nurses. Models such as 4/40 (four ten-hour shifts), 7/70 (seven ten-hour shifts) and three twelve-hour shifts per week, have demonstrated their ability to maintain optimal patient outcomes and high nurse retention rates (Froedtert Hospital, 2006). These scheduling models have thus far not been researched in relation to fatigue in nurses.

The increased risk of error associated with fatigue has necessitated the development of recommendations based on evidence in order to decrease fatigue in relation to nurse scheduling. Based on the evidence available, recommendations were synthesized from the literature. Please note that "on call" nursing was not included in this synthesis and could be a focus for future study.

Synthesis of Evidence with Recommendations for Practice and Future Research

Problem

- As many as 40% of nurses reported working overtime (Rogers et al., 2004b).
- Over two-thirds of nurses reported working more than 12 hours in one day (Scott et al., 2006).
- Fourteen percent of nurses worked 16 or more hours at least once over a four-week period (Rogers et al., 2004b).
- Almost two-thirds of nurses reported working overtime 10 or more times during a four-week period (Rogers et al., 2004b).
- Nurses reported having a break or meal period free of patient care responsibilities less than half of the shifts worked (Rogers et al., 2004a).
- Twenty percent of nurses reported falling asleep once during their work shift (Scott et al, 2006).
- Chance of error increases with prolonged work shifts (IOM, 2004).

Definitions

- "Direct patient care encompasses activities carried out in the presence of the patient and family, such as performing a physical exam and other assessments of the patient, administering medications, and performing treatments and procedures" (IOM, 2004, p. 36).
- Fatigue is a protective response, an indicator of an individual's response to physical and psychological demands. It is an awareness of a decreased capacity of activity (physical and/or mental) attributed to an imbalance in the availability, utilization and or restoration of the resources an individual needs to perform activity (Ruggiero, 2003).
- Chronic fatigue is a general tiredness and lack of energy irrespective of sleep quantity or hard work (Ruggeiro, 2003).

Scientific Merit

- A number of primary studies reviewed included nurses' work schedules, measures of nurse responses to the work schedule or patient outcomes. A number of review articles were located. See evidence tables for detailed information.
- One study (Smith-Coggins, 2006) used an experimental design. All others studies used descriptive (including qualitative) or correlational designs hence evidence is weak as it is associational, not causative.
- Samples were drawn from acute care facilities. Sample size varied widely ranging from 6 to 2273 (5 studies with samples under 100; four under 200; 6 under 400; 2 greater than 1100). Consistent with the profession, the samples were primarily females. All samples except Scott (2006) were convenience samples.
- The most common work schedules included in the studies were 8, 10, or 12 hours; but also included 9 or 11 hour shifts (Josten, Ng-A-Tham & Theirry, 2003). Some studies explored differences between shifts (morning, evening, and night) (Dorrian et al., 2006; Kunert et al, 2007: Ruggiero, 2003). In the review of literature, overtime was evaluated and ranged from less than ten minutes past the end of ones shift to working a complete extra shift (Rogers et al., 2004b; Scott et al., 2006; Trinkoff et al., 2006).

- Although fatigue and error were the most commonly measured, outcomes were numerous and included driving drowsiness, sleep patterns, patient satisfaction, communication, depression, anxiety, and health complaints.
- Measurement instruments consisted primarily of self-report via logbooks or verbal report (Dorrian et al., 2006). Measures also included neurobehavioral performance simulated testing (Dorrian, Lamond, & Dawson, 2000); measures of brain waves polysomnography (Smith Coggins et al., 2006); review of medical records (Gillespie & Curzio, 1996); personnel records (e.g., absenteeism) (Gillespie & Curzio, 1996); and psychometric instruments (Ruggiero, 2003).
- Common threats to the internal validity of the studies included selection bias, low response rates (20%) (Josten et al., 2003), and use of measurement tools without established reliability and validity.
- Potentially confounding factors not studied included staffing adequacy (acuity of patients and nurse-to-patient ratios), additional professional commitments, full-time vs. part-time, critical versus acute care units, personal preference, and use of agency staffing.

Findings

- Evidence was weak but consistent in that working more than 12 hours in a single day was associated with errors (Montgomery, 2007; Rogers et al., 2004b; Scott et al., 2006). The IOM (2004) reports error rate doubles after 12 hours.
- Again, evidence is weak, but consistent overtime is associated with errors (Montgomery, 2007; Rogers et al., 2004; Scott et al., 2006). However, no evidence that the reason (mandatory vs. voluntary) for overtime makes a difference (Rogers et al., 2004b).
- One descriptive article reported that the risks of nurses making an error were increased when they worked greater than 40 hours per week (Rogers et al., 2004b). However, there was no delineation as to what type of shifts were worked to exceed 40 hours.
- The only other study referring to impact of number of hours worked per week was a recommendation for truck drivers (Jha et al., 2001; IOM, 2004).
- In a state of the science article Knauth (1993) recommended at least two successive days off if 5 to 7 days are worked consecutively.
- There was weak and limited evidence that night nurses reported increased fatigue and nurses over the age of 40 reported more fatigue when working longer hours (Kunert et al., 2007; Muecke, 2005).
- There was weak and limited evidence that recovery time between shifts decreases fatigue, a factor affecting rotation and alternative scheduling systems (Hughes, 2004; IOM, 2004; Meucke, 2005). One study found that increasing shift length while increasing recovery time resulted in less fatigue (Josten et al., 2003); a recommendation supported by Knauth (1993)
- Scheduling naps was the only intervention tested and was associated with both positive and negative outcomes (Smith-Coggins et al., 2006).
- The 60 hour work week limit suggested by the IOM has been inadequately validated by research, specifically in relation to nurse scheduling (see Evidence Tables I & II).

Recommendations for Future Research Based on Gaps in the Evidence

1. Recommend support of state and national organizations to fund studies related to work schedule, nurse fatigue, and patient outcomes.
2. Evaluate the impact of time-off between shifts and recovery time needed to minimize fatigue.
3. Evaluate the impact of personal preference of work schedule related to fatigue and errors.
4. Study the combination of work schedule and staffing on patient safety and nurse fatigue.
5. Evaluate the cumulative effect of hours per day worked with hours per week worked.

Summary of Recommendation for Practice Based on Synthesis of the Evidence

1. **Limit scheduled shifts to 12 hours or less in a 24 hour period** (Caruso, Hitchcock, Dick, Russo, & Schmit, 2004; Gillespie & Curzio, 1996; IOM, 2004; Montgomery, 2007; Rogers et al., 2004b; Scott et al., 2006; Trinkoff et al., 2006).
2. **Increase awareness that fatigue varies across shifts and consider this when developing staffing schedules** (Dorrian et al., 2006; Ruggierro, 2003).
3. **Strongly recommend adequate rest to be obtained between shifts (i.e. 10 hours after an 8-hour shift and 12 hours after a 12-hour shift)** (Gillespie & Curzio, 1996; Hughes, 2004; Knauth, 1993).
4. **Encourage staff to schedule time for breaks and meals. Management must put a structure in place that allows this to occur** (Rogers et al., 2004a; Hughes, 2004).
5. **Avoid shift rotation. If necessary to rotate shifts, facilitate shifts with forward rotations (morning to night)** (Dean et al., 2006; Hughes, 2004; Knauth, 1993; Muecke, 2005).
6. **Educate nurses about proper sleep hygiene** (Dean et al., 2006).
7. **Educate staff on personal responsibility to not work when too fatigued** (Department of Government Affairs, 2007; Hughes, 2005).
8. **Encourage state and national funding agencies to support study of innovative work schedules.**

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Rural Wisconsin Health Cooperative

TO: Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
Senator Jon Erpenbach, Chairperson

FROM: Jeremy Levin, Director of Advocacy
Rural Wisconsin Health Cooperative

DATE: April 22, 2009

RE: **OPPOSE** Senate Bill 108 – Prohibiting Mandatory Overtime Hours by Health Care Workers

On behalf of our thirty-five member rural hospitals, who take pride in serving their communities, the Rural Wisconsin Health Cooperative (RWHC) thanks you for this opportunity to share our thoughts on Senate Bill 108, relating to mandatory overtime hours and on-call time worked by health care workers and providing penalties. The RWHC opposes the prohibition of using mandatory overtime to cover unanticipated health care worker shortages at a health care facility.

According to a 2008 study prepared for the Wisconsin Organization of Nurse Executives, different factors lead to nurses working long hours. Among them:

- Patients in acute care facilities must be cared for by nurses around the clock.
- Hospitalized patients are more acutely ill requiring lower nurse to patient ratio.

These factors are just some of the contributing sources of fatigue that nurses experience in the modern health care system. Combating fatigue among all our health care workers is everyone's goal. There is a well-documented nursing shortage, although Wisconsin is not experiencing the degree in the shortage of nurses as compared to other regions of the country. Over 30 schools of nursing provide over 2000 graduates yearly to Wisconsin's health care agencies. However, even with a better supply of nurses than other regions, we could still use more and even the best staffing strategies cannot completely avoid the use of overtime, a majority of which is voluntarily taken.

In the 24-hour, year-round environment of hospitals and other health care facilities, making sure proper patient coverage and care is paramount. Patient intake can uptick quickly, adverse weather conditions can delay or nurses may become ill themselves. All of these occurrences are amplified in rural areas, where travel time and options are more stressed. Even with these unpredictable changes, mandatory overtime is never the first strategy for staffing. Senate Bill 108 is a "one-size-fits-all" approach to hospital staffing and it does not reflect the fact, which is borne out by studies that mandatory overtime rarely occurs. A Wisconsin Hospital Association study of nurses conducted with the Wisconsin Department of Workforce Development indicates that only 7.8% of RNs had ever experienced mandatory overtime. Often times that mandatory overtime is not for another complete shift, but to cover until the scheduled nurse arrives or until the shift is filled on a voluntary basis.

Limiting the tools available to hospitals impairs their ability to insure that the correct number of staff is available whenever and wherever the need presents. SB 108would limit the options available to healthcare facilities as they struggle to staff for unpredictable patient care demands. It is not possible to simply not care for patients. Their safety is compromised when sufficient staffing is unavailable. While a last resort of many existing ways to manage patient care needs, mandatory overtime should remain a tool to be used in times of extreme circumstances.

Wisconsin's rural hospitals are strongly committed to improving patient safety. Our goal is to strike the appropriate balance between safety, quality and patient-centered care. The RWHC asks the committee members to **OPPOSE** Senate Bill 108, prohibiting the use of mandatory overtime. Hospitals and other health care facilities need self-determination over their individual staffing situation and the flexibility to handle any unintended staff coverage emergencies.

880 Independence Lane • Sauk City, Wisconsin 53583 • (608) 643-2343 • FAX (608) 643-4936 • www.rwhc.com

April 22, 2009

My name is Sue Schweitzer and I am here today to testify in opposition to Senate Bill 108 (Banning Mandatory Over time) on behalf of the Columbus Community Hospital.

In my practice as a staff nurse in surgery and now as the Director of Outpatient Services, mandatory overtime has never been considered a desirable strategy when an unplanned staffing situation occurs. Nurses take their responsibility to their patients very seriously and my experience has been that they rise to the occasion to meet the staffing needs of their patients. However, I am very concerned with legislation that would restrict our ability to expect staff to stay in situations that could impact safe patient care.

I am particularly concerned with the language that specifically defines the term, "unforeseeable emergency." Our hospital relies on more than half of our admissions from patients who present to our emergency department rather than elective or planned procedures such as surgeries, which makes predictability of volumes on a daily basis very difficult. We are also seeing more patients being directly admitted from physicians' offices as they are waiting until they are acutely ill before making the decision to seek medical care, as a result of the high cost of this care. The increased demand for providing services to Observation status patients who do not immediately meet criteria for inpatient admission is another contributing factor to the unpredictability of health care as a business. Care of these patients demands an active treatment plan meaning their need for service is short but intense. Though we utilize tools to identify periods of highest patient demand in order to staff accordingly, matching patient needs with the need for efficient utilization of human resources remains a balancing exercise as illustrated by an actual situation that has occurred in one of my departments:

The Surgical Services nursing staff is scheduled from 6:30am -3:00pm Monday through Friday, with one On Call team available from 3:00pm to 7:00am the next day. Circumstances sometimes arise that elective cases are not completed by the 3:00pm end of the shift, so the on call staff takes over to finish these cases. Situations have occurred that just as staff was preparing to leave for the day, the decision is made that a laboring patient requires an emergent cesarean section. The On Call staff is already engaged in the care of the case in progress. This bill would inhibit our ability to expect staff not scheduled beyond the 3:00pm shift, to stay to provide the emergent care. If none of the staff nurses had agreed to stay beyond their shift, that laboring patient and her unborn child would have needed to be immediately transferred to another facility putting her and her baby in a high risk situation.

While mandatory overtime is truly considered only a strategy of last resort, I ask that it remain a tool available to be used in extreme circumstances to assure patient safety.

Thank you,

Sue Schweitzer, RN, BSN
Director of Outpatient Services
Columbus Community Hospital

WISCONSIN HOSPITAL ASSOCIATION, INC.

To: Members of the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue

From: Judy Warmuth, RN, PhD, Vice President-Workforce
Wisconsin Hospital Association

Date: April 22, 2009

RE: Testimony in Opposition to SB 108

Hospitals are very concerned about patient safety. I would provide as evidence the fact that all of Wisconsin's hospitals publicly report patient safety measures on the Wisconsin Hospital Association (WHA) CheckPoint website, and that WHA has led community and statewide initiatives on error reduction.

WHA is opposed to SB 108 because it takes away an important and rarely used safety net that allows hospitals to assure that there will be staff to care for patients in unforeseen circumstances; it limits the options hospitals have to meet unexpected patient care needs and; it does not address the more frequent and larger issues of fatigue and extended hours of work

As health care providers, we are concerned by the total hours worked by employees and by the risk created by fatigue to patients and to employees. Hospitals and other employers are taking a proactive approach to address this. For example, WHA has a seat on The Safety Partnership, a group within the Department of Workforce Development (DWD) that is working on a project relating to extended work hours and fatigue across many occupations. The group is developing strategies to inform employees and employers of injury rates and decline in performance that result from prolonged work hours. The group is also looking to present strategies, solutions and interventions to help workers and employers address these concerns.

WHA believes the discussion on fatigue should focus *not* on mandated hours, which research shows are a very small part of the total overtime hours, but on total hours worked, recovery time, and the effects of fatigue on patient safety. Unfortunately, SB 108 focuses only on one small part of this broad picture. It is only by looking at this full picture that we will develop appropriate solutions.

There is now enough research to allow an evidence-based discussion of fatigue, overtime and patient safety. That research indicates the following:

- Studies of health effects of extended hours in other industries have found no correlation between those effects and whether extended hours are required or voluntary, suggesting that the health impact is comparable, regardless of this distinction. (Trinkoff, et al, 2006)

- While nurses work longer than their shift length 81% of the time, only 6% of that time is mandated. (Rogers, 2004) Dr. Rogers reported the same figure to an American Nurses Association (ANA) meeting in 2005.
- When nurses do work overtime, the average amount of time worked over scheduled hours is 49 minutes. (Scott, et al 1/2006)
- Nineteen percent of nurses work two or more jobs. (Trinkoff, et al, 2006 and Scott et al 2/2006)
- Errors and near errors are more likely to occur when nurses work 12 or more hours. (Rogers, et al, 2004)
- The National Institute of Occupational Safety and Health (NIOSH) has reviewed published studies across all industries relating to long work hours and found that deteriorating performance for 12-hour shifts was found only with work weeks longer than 40 hours. (April 2004)
- Work hours for medical residents have been restricted to 80 hours per week. Evidence after several years is mixed, with no clear patient advantage.

And from that evidence-based research, organizations have made recommendations relating to this issue:

- The Joint Commission has recommended four strategies to minimize fatigue and its effects. Schedule work and on-call hours to reduce fatigue; limit work hours; identify tasks that should not be done by individuals on extended work hours; and use safeguards to ensure that procedures are done correctly.
- The Institute of Medicine (IOM) has recommended that nurses should not provide care in any combination of scheduled shifts, voluntary or mandatory overtime in excess of 12 hours in 24; and no more that 60 hours in a 7-day period. The report also discusses recovery time, but makes no recommendations.
- The American Nurses Association (ANA) has position statements for both employers and nurses relating to work hours and fatigue. These statements speak to rest and recuperation between shifts.
- The Wisconsin Nursing Consortium has a statement on hours of work and fatigue that is similar to the ANA position.

Changes have been made to this bill since the last time it was introduced making it especially concerning to Wisconsin hospitals. This bill is very restrictive in its definition of situations in which mandatory overtime may be used. It does not recognize those rare, but possible situations where unanticipated census spikes, changes in acuity or staff absences make it impossible to care for our patients. This bill has new restrictions on on-call which limit a hospital's strategies to prevent mandatory overtime. This bill prohibits bargaining on the use of mandatory overtime. This bill uses new strong language regarding retaliation, a place where Wisconsin already offers strong worker protection. This bill is more distressing to hospitals than previous versions.

A mandate on employers, such as contained in SB 108, ignores the independence of employees to hold multiple positions, and to work in schedules that fit within lives and lifestyles, and also workers' responsibility to be rested when presenting for work. A simple mandate addressing only one piece of this complex equation is not a solution and does not provide the assurances needed.

WHA has taken action to address fatigue and long hours of work. The WHA Board of Directors has approved a position paper which outlines the responsibilities of both employers and

employees related to fatigue. WHA has had educational programs for hospital leaders around readiness for work. Our members have discussed best practices and shared policies that create safe staffing programs and reduce the risk of employee fatigue and fatigue related errors. As the amount of evidence increases, we have moved to design practices based on this evidence.

Fatigue and long hours of work and recovery can be addressed, but SB 108 does not do so. We believe there are other, far better ways to assure safety for patients and employees.

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Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Senator, Jon Erpenbach, Chair

Testimony of Mary Cieslak Duchek
Director of Nursing Integration, Aurora Health Care
2009 Senate Bill 108
Relating to the banning of mandatory overtime for certain health care workers.
Room 411, South, State Capitol
Wednesday, April 22, 2009, 10:00 a.m.

Chairperson Erpenbach and members of the Committee, thank you for the opportunity to appear on behalf of Aurora Health Care to speak about our concerns regarding 2009 Senate Bill 108.

My name is Mary Cieslak Duchek, and I direct nursing integration at Aurora Health Care. Aurora is a not-for-profit integrated health care system with over 28,000 caregivers serving two million patients annually through our 13 hospitals, 120 outpatient clinics, 120 pharmacies, visiting nurse association and hospice services. We are Wisconsin's largest private employer serving patients in 95 urban and rural communities covering the eastern half of Wisconsin, from the Illinois border to the Michigan border. In addition to my executive role at Aurora, and I have been a nurse for over 30 years and also currently serve as the Co-Chair of the Legislative Committee of the Wisconsin Organization of Nurse Executives.

I have been the chief nurse at a small community hospital as well as at a large tertiary care facility. In both these roles I had been challenged with staffing unpredictable community emergencies that required the hospital to quickly manage crisis situations. These experiences, as well as an understanding of our hospitals recent challenges bring me today to explain why such legislation is not safe for patients.

The leadership of Aurora Health Care is committed to continuously evaluating the needs of patients and the resources required to care for them. Patient safety is the first priority when planning staffing needs. Mandatory overtime is sometimes necessary based upon specific circumstances impacting patient safety. At Aurora, mandatory overtime is used on rare occasions as a last resort.

Mandatory overtime bans don't reflect the realities of providing a diverse range of patient care in the hospital setting. Patients' care needs are increasingly complex as the population ages; care protocols prescribe consistent treatment plans, socioeconomic factors influence disease management and outcomes are monitored. Patient care is simply more complex than a ban on mandatory overtime would suggest.

The following real life examples demonstrate the difficulty with imposing a one-size-fits-all ban on mandatory overtime.

- A bus crash occurred which involved 13 patients, which were also unfortunately incarcerated prisoners and required further security measures. Our facility was able to address this situation but it not only required clinical staff but additional security staff to manage the unique needs of the situation.

- In February of this year the transplant unit at Aurora St. Luke's Medical Center received word that three patients would receive organs within a few hours of each other. So this miraculous event required staff from four areas to quickly add staff to the day's schedule.

- Normal public health determinations to declare an outbreak can take days and even weeks before becoming an official "disaster." A cryptosporidium outbreak in metro-Milwaukee several years ago resulted in patients rapidly appearing at hospitals. Two weeks later the City of Milwaukee Health Department became aware of the epidemic, which led to the Mayor declaring a "boil water advisory."

It is ambiguous as to whether these examples would meet the definition of a "disaster" or "unforeseen" event given the bill draft's wording. SB 108 also contains definitions that appear incomplete for "on call" scheduling.

The enforcement mechanism is very broadly worded, and the Department of Workforce Development is tasked with being the first stop for an employee grievance, with no filtering process prior to that.

Our concern is that legislation like this has a chilling effect for nurse supervisors who might fear that any decision on how to parse this bill's language could lead to hefty fines, simply based on a difference of opinion, or misperception by a health care worker or DWD staffer.

To address staffing challenges employment agreements currently serve to create a common understanding around the employees' work schedule and the employer requirements for staffing. Work/ life balance is needed for employees and employment agreements add predictability to schedules yet address the patients' needs in clinical areas.

Aurora Health Care appreciates the bill's intent to promote the safety of Wisconsin patients. All caregivers and their employers share this same concern as a priority.

However, SB 108 will not help us achieve greater patient safety.

Thank you for allowing me to appear today to share our concerns with you.

April 22, 2009

My name is Lu Ann Reuter, RN and I am providing written testimony to oppose Senate Bill 108 (Banning Mandatory Overtime) on behalf of Columbus Community Hospital and as a member of the Rural Wisconsin Health Coop.

As a nursing supervisor for the Emergency Room in a rural community, I have great concerns about the Senate Bill 108 which is not allowing for overtime of staff for the unexpected changes in patient census, acuity or staff related issues.

In the Emergency Room we staff for a daily census of 28 patients in a 24 hour period. Our staffing pattern changes according to daily census which is based on our MESH system. As healthcare providers we know that the census and acuity can change and fluctuate at any given time. Because of these unexpected situations it may be necessary for the ER staff to have to fluctuate their hours to accommodate the patient(s) and to provide safe patient care. This may require us to look at our other staff members to help alleviate any potential unsafe situation.

Small rural hospitals do not have the flexibility that a large urban hospital has in regards to extra available staff. Larger hospitals may be able to access additional staff from other various units within their hospital. They may have an in house float pool/mobile nurse or per diem staff that may be able to fill the unexpected need. As a small rural hospital our "nursing pool" is very limited to our department. We are a specialized unit which requires special training. We look to our own staff who are currently staffing, those who are not working a particular shift, and those who can be called in early for the next shift to help with the unexpected census changes or for staffing related issues such as ill calls, jury duty, and Family Medical leave.

Here are a couple of examples of unforeseeable situations that have occurred at our facility that would be impacted negatively by this bill.

Example 1:

Our staffing is usually 2 RN's from 7am-11Pm, a LPN/EMT-I who is usually scheduled from 9am-9:30pm, and a Unit Coordinator from 9am-9:30pm. We had a critical patient from a motor vehicle accident admitted to the ER with life threatening injuries at shift change. The ER was at maximum capacity with sick patients and some urgent care patients. The patient to nurse ratio was high and it was very important for patient safety to have the additional staff stay beyond their scheduled shift to provide safe patient care. Had this occurred during the middle of a shift, this bill would prevent requesting additional staff to work beyond their agreed upon scheduled shift, call in PRN staff or requesting staff who are not scheduled to come in. Timely critical interventions could not be delayed in order to avoid unnecessary complications or death.

Example 2:

The ER had 2 nursing staff who called in sick within a 24 hour period. In order for these hours to be covered to provide safe patient care, additional staff was needed. I had the 8 hour day shift nurse pick up additional 4 hours and the 8 hour night nurse picked up 4 additional hours and I also had to call in extra staff to help staff the unit according to our MESH. This bill would prevent the current staff, the staff who are not currently scheduled or the PRN staff from providing adequate and safe nursing care.

As you can see, small rural community hospitals may be greatly affected by Senate Bill 108. We staff according to our average daily census. Unfortunately, we do not have extra staff that is available to us for the unexpected situations whether it be for patients or staff members. We need the flexibility to utilize our staff for the unexpected changes in census, ill calls, or any other situation that occurs that would require additional staff.

At Columbus Community Hospital, we are very cognizant of the nursing schedules and staff fatigue. The scheduling process includes an awareness of staff availability and fatigue. However, our nursing availability is very limited when the unexpected situations require additional staff.

I have never had to mandate staff to work extra, stay over to the next shift or come in early for their shift. The staff is willing to pick up the extra hours to ensure safe patient care. Safety is compromised when there is insufficient staffing. While mandatory overtime should be a last resort, this should remain a tool to be used in extreme circumstances to provide safe patient care. Senate Bill 108 does not allow this.

We at CCH, have always been cognizant of a nurses need for breaks/rest periods and the number of hours worked to not contribute to fatigue or potential patient safety issues.

Thank-you.

Lu Ann Reuter, RN

Emergency Room Supervisor

Columbus Community Hospital

Written Testimony Opposing Legislation on Mandatory Overtime

As Vice President of Patient Services at a small community hospital and current President of the Wisconsin Organization of Nurse Executives (W-ONE), I am writing today to state my concern about and opposition to Senate Bill 108. I know from first-hand experience the challenges of staffing most departments of any hospital; rural or urban; large or small; profit or not for profit. The demand for staff in a given department can literally change at a moments notice. Hospitals do not control the volume of patients or their acuity. We consistently strive to give excellent care to every patient every day. However, excellent care cannot be provided unless optimal staffing levels are achieved. Hospitals generally have a staffing plan for each area based on an average census. However, if a motor vehicle accident, explosion, severe weather or any number of other incidents occur, the need for staff in our Emergency Departments, Medical & Surgical areas and Critical care Units will change dramatically in a heartbeat. And, we all know that babies will arrive on their own schedule at all hours of the day or night. We attempt to anticipate changing needs by creating float pools and hiring extra "casual" or "vacancy relief" staff. We offer bonuses and incentives to entice staff to be flexible. We utilize costly supplemental staffing resources on both a short and long term basis as necessary. We even "over hire" and schedule more staff than is routinely expected in many cases. However, the individual who is scheduled and then "laid off" if an unanticipated surge in patient census does not materialize becomes a very unhappy worker very quickly because of the inability to earn enough to support him or herself and family. Since the above strategies are in place, mandatory overtime is not used for routine staffing needs. By implementing legislation in opposition to mandatory overtime, my fear is that in the rare times of extreme need when significant unanticipated patient influx occurs, patients may receive less than optimal, or even substandard care due to insufficient numbers of staff willing to respond. Or, the patient may need to be transferred to another facility resulting in a delay in appropriate care.

The W-ONE Board of Directors has also had many conversations related to healthcare worker fatigue. We support the recommendations found in "Fatigue at Work," a document compiled by the Safety Partnership Committee which is comprised of a number of state and federal agencies and groups. We recognize that fatigue is frequently attributed to excessive work hours and endorse the need for a Fatigue Management Plan. Such a plan would require cooperation between employees and employers and address the fact that excessive work hours, whether mandatory or voluntary, can contribute to unsafe work environments and issues of safety in patient care. Therefore, any legislation that addresses mandatory limits on work hours should also address hours worked voluntarily by staff in one, or in multiple, organizations. Please know that legislation related to mandatory overtime will not adequately address issues of staff fatigue.

I appreciate this committee taking the time to hear testimony on both sides of the issue today. Please know that proactive approaches to staffing issues have been developed by Wisconsin hospitals. Nursing leaders across the state and the Wisconsin Organization of Nurse Executives have consistently made decisions to assure optimal care of the patients entrusted to our facilities. We are committed to hiring adequate numbers of staff and putting in place systems to assure that our staff does not suffer from excessive fatigue related to many hours of work. A legislated solution is not necessary and may actually result in unintended harm to patients if enacted. Think about a sudden, unanticipated surge in the need for emergency services and/or inpatient care. Think also about it being your spouse, child, parent or best friend presenting with serious illness or injury during that time. We owe it to our patients and our communities to do good planning for staff coverage, and that is our commitment as hospital leaders. However, we also owe it to our patients that someone will be there to take care of them during those times of high, unexpected patient census. Please do not enact legislation that would make an already difficult task even more complex and potentially unsafe.

Peggy Ose, RN, MSN, FACHE
Vice President – Patient Services/Chief Nursing Officer
President – Wisconsin Organization of Nurse Executives

04/21/09

Good Morning Chair Erpenbach and Members of the Committee,

My name is Beverly Hoege and I am writing today to testify in opposition to Senate Bill 108 / Assembly Bill 152 on behalf of the Wisconsin Organization of Nurse Executives (WONE) and Reedsburg Area Medical Center. WONE represents over 225 nurse administrators, managers and faculty members of Wisconsin's hospitals, health care agencies and schools of nursing. The WONE opposes Senate Bill 108 /Assembly Bill 152 because health care agencies currently maintain effective staffing resources and rarely utilize Mandatory Overtime (MOT). I believe these staffing issues need not be legislated.

I am the Chief Nursing Officer at Reedsburg Area Medical Center, a 25 bed critical access facility. We deliver about 275 babies, perform 2500 surgical procedures, care for 13,223 ER/UC patients, and 1883 inpatient (IP) annually.

The issue in small facilities is the major fluctuations in census, or unanticipated staff absences, and the need to deal with major traumas or disaster that may come through our door. Interestingly enough, women labor and babies are born according to their time clock and not necessarily convenient to a staffing pattern. On New Year's Day the OB Unit was closed and within 1 hour four mothers presented inactive labor and delivered within a few hour timeline. We typically staff for two babies and moms. We asked for extra staff to provide safe, quality care. Fortunately, we have not had to mandate.

IP census, number of births occurring or number of patients being seen may vary 200 – 400% within 8 hours. This requires flexibility and creativity of staffing plans. For example, Med/Surg IP census was 9 – within several hours the IP census was 22. Diagnosis and acuity varied, once again requiring flexibility. Staffing is adjusted based on the patient acuity system which identifies the number of RN, LPN, or Nursing Assistant hours needed to provide care. ICU – IP census goes from 0 to 5, admitting and discharging, within 8 hours. These changes require flexibility. How are we to manage unexpected community crisis or deal with unanticipated staff absences?

This bill will eliminate an option from the manager's toolbox. We choose not to use MOT, however, to say we never could use MOT, could impact safe delivery of care. These are management not legislative issues.

For the above reasons I register in opposition to Senate Bill 108 /Assembly Bill 152.

Thank you,

Beverly L. Hoege

Beverly L. Hoege
510 Franklin Street
Reedsburg, WI 53959

My name is Kay Caldwell and I am providing written testimony and to oppose Senate Bill 108 (Banning Mandatory Over time) on behalf of the Columbus Community Hospital and as a member of the Rural Wisconsin Health Cooperative.

As a Nursing Supervisor for a small rural community hospital with a14 bed MedSurg unit, 4 bed ICU and 5 bed Swing Bed unit, I see great concerns with not allowing for overtime of staff for unexpected changes in census or patient acuity.

As a small rural community hospital, we typically staff for an average daily census. But, as all healthcare workers in rural communities know, census can fluctuate dramatically at a moment's notice. Because of these unexpected situations, we may have a census change that may be much higher than our average daily census and our staffing levels provide. When this occurs, we often look to our staff to help alleviate any potential unsafe staffing levels.

Small rural hospitals don't have the flexibility that large urban based hospitals have for census fluctuations. Larger hospitals may have access to staff from various units around their hospital or have an in house pool/per diem staff to use to fill needs for unexpected situations. As a small rural hospital, we do not have multiple medical units to shift patients/admit patients to. We look to our own staff – staff that are not working that particular shift, staff that are currently working, or staff that can come in early to work to help with these unexpected census changes, PRN staff, and agency staff.

Here are a couple of examples of unforeseeable situations that have occurred at our facility that would be impacted negatively by this bill.

Example 1:
Our typical staffing level for a PM shift in the ICU is 1 RN. Medsurg has an average census of 12 and is staffed accordingly. If the ICU has 3 patients already and a patient comes into our ED and needs to be admitted to the ICU, my nurse to patient ratio (based on MESH acuity/nurse needs) will often be higher than the amount of nurses I have available to staff that unit. This bill would prevent requesting staff not previously scheduled, PRN staff, agency staff, or current staff to provide adequate staffing to care for the additional ICU patient. The only other option would be to divert the patient (which has been done in the past due to no availability of staff), which results in delayed care and treatment of the patient.

Example 2:
One of the RN's that is to work calls in ill a couple hours prior to the start of the shift. Due to the current census, I need to replace this nurse to maintain an adequate level of staffing for safe patient care. Based on SB Bill 108, I would be prohibited from requesting a nurse to work overtime due to the nurse not previously agreeing to and having been scheduled to work this shift. This increases the current workload of the staff already scheduled and impacts patient care. My concern is how this bill is increasing the potential risk in patient care by not allowing flexibility in unforeseen situations as this.

As you can see by my examples, small rural community hospitals may be greatly affected by Senate Bill 108. We staff to an average daily census which is adequate the majority of time. We don't always have extra staff available to fill in for unexpected situations. We do not have the luxury of being able to admit to various units within our facility or have staff from various units available to float to help alleviate unexpected staffing issues as may be the case in larger urban hospitals. We need the flexibility to utilize our staff for unexpected changes in census, ill calls or any other situation that occurs that would require an increase level of nursing needs.

At Columbus Community Hospital, we are very cognizant of nurse scheduling, staff fatigue, nurses' need for breaks/rest periods and the number of hours worked so as not to contribute to fatigue or potential patient safety issues because of overtime.
Although I have never mandated staff to work extra, stay over to the next shift or come in early for their shift, we do need the option of allowing staff willing to work above their previously agreed upon schedule available to us for safe patient care delivery in unexpected situations. Safety is compromised when sufficient staffing is not available. While mandatory overtime should be a last resort, this should remain a tool to be used in extreme circumstances to provide safe patient care. Senate Bill 108 does not allow for this.

Thank you.

Kay Caldwell, RN
M/S, Swing Bed, ICU Supervisor
Columbus Community Hospital

To : Members of the Assembly Committee on Health Care and Health Care Reform

From: Terri Harmon RN, Director of Nursing Administration, Beloit Memorial Hospital

Date: April 15, 2009

Regarding: Written testimony in opposition to Senate Bill 108

I am sorry I am unable to be in attendance at today's hearing, but I want to submit my written testimony in opposition to Senate Bill 108, thank you for accepting this.

My name is Terri Harmon, and I have been a nurse since 1982, and am currently the Director of Nursing Administration at Beloit Memorial Hospital in Beloit, Wisconsin. I am writing in opposition to Senate Bill 108 banning mandatory overtime for healthcare workers.

I am in my 27th year of employment at Beloit Memorial Hospital, as a nurse, and 14 years of that was as a Critical Care Nurse, and the last nine in my present managerial position. As a staff nurse, in critical care, nor anytime during my employment at Beloit Memorial has it ever been mandatory to work overtime. It has always been the culture here, to give high quality patient care no matter what the circumstance might be. Heart attacks, motor vehicle accidents, and other traumas do not wait until hospitals have adequate staffing. Since we do live in the mid west, we do have to contend with the affects of snowstorms, and the inability of staff getting to work in a timely fashion. This bill provides no option for times such as this!

As Director of Nursing Administration, I have direct responsibility for staffing and in my career at Beloit Memorial Hospital, I know of no instance of mandatory overtime. We encourage our staff to work overtime by offering them good pay, treating them with respect, and giving them the option not to work overtime. This bill does not provide solutions to problems; it promotes obstacles to good and safe healthcare.

I urge you to vote against Senate Bill 108, and together address real healthcare issues in our state.

Testimony Statement SB 108 Mandatory Overtime

Honorable Legislators,

My name is Ivar "Skip" Gjolberg PT, I have worked in healthcare for 20 years, to include psychiatric care, level I trauma, outpatient services, long-term care and home health. The bulk of my career has been as a physical therapist in an acute care environment. I currently work in administration at St. Joseph's Hospital (SJH) in Chippewa Falls, a licensed 150-bed acute care hospital that has been providing care for over 125 years to the Chippewa Valley. We are part of the 13 hospital Hospital Sister's Health System.

I am here today to speak against the 2009 Senate Bill 108, making mandatory overtime (OT) illegal except in emergencies. First, I want to make it clear that this bill is not a good idea for patients. This legislation has the potential to adversely impact both patient safety and the high quality of care Wisconsin hospitals are known for.

I cannot speak on the conditions for every hospital in the State of Wisconsin; I can only speak on the practice of SJH and our sister hospital, Sacred Heart Hospital (SHH), in Eau Claire. Our nursing turnover is very low, 13-18%. Our nurses are very happy with the work they do and the conditions within which they work. We have documented this fact with our ongoing colleague opinion surveys, reviewing our exit interviews and by our low turnover percentage. We have never had a colleague leave employment because of mandatory overtime. This is not to say that we have not had to use mandatory overtime but it is a very rare case. The last time SJH had to use mandatory over time was during a blizzard a few years ago. We had to do so because colleagues could not get into work. If the ability to provide care for this patient had been restricted by the statute we are debating today, the safety and quality of the care we provided that day would have been compromised. At SHH, mandatory OT was used approximately 15-20 times in the past year out of thousands of shifts. Mandatory OT is only used after we have made every attempt to find colleagues to volunteer or call colleagues in. It is a last resort approach!

As an administrator, it has never been our practice to use mandatory OT as part of our staffing strategy. That is senseless, irresponsible and not in concert with sound business practices. To maintain a quality workforce providing the best patient care possible, routinely using mandatory OT is "frankly stupid". SJH inpatient satisfaction scores have been above the 95th percentile for 10 quarters. This was completed by using the servant leadership model exemplified by all of our colleagues from our housekeeping and food service colleagues down to the CEO, David Fish. It makes no sense to routinely operate from a perspective that would alienate your key hospital healthcare provider. Any hospital that cares about their quality, the safety of their patient care and the workforce would not do this.

Granted, there may be some providers who have abused or misused this authority. No industry is without its' outliers, but do not enact broad sweeping legislation that will impact literally thousands of healthcare employers for a few problematic providers. One law fits all will not work. Good hospitals that provide good quality care and needed jobs in rural, urban, and metropolitan areas do not need another legislative mandate to deal with in these trying economic times. Wisconsin hospitals are doing a great job with transparency of quality; WHA's Checkpoint and CMS's HCAHPS are a few ways consumers can see the quality that is out there

TESTIMONY IN OPPOSITION
SENATE BILL 108 (BANNING MANDATORY OVERTIME)

My name is Ellen Zwirlein and I cannot be here today but wish to offer testimony in opposition to Senate Bill 108. I am the Director of Patient Services at Prairie du Chien Memorial Hospital which is a 25 bed Critical Access hospital. I am also a WONE Board member. The WONE opposes Senate Bill 108 because health care agencies currently maintain effective supplemental staffing resources and rarely utilize mandatory overtime (MOT) and this bill does not support the (2004) Institute of Medicine's Recommendations for Transforming the Work Environment of Nurses.

I have been an RN in a rural hospital for over 35 years. During that time mandatory overtime has never been utilized. Mandatory overtime is never a first, or even a second strategy for staffing. Senate Bill 108 is a "one-size-fits-all" approach to hospital staffing and it does not reflect the fact, which is born out by studies that mandatory overtime rarely occurs. Limiting the tools available to hospitals impairs their ability to insure that the correct number of staff are available whenever and wherever the need. Senate Bill 108 is one of those factors that would limit the options available to healthcare facilities as they struggle to staff for unpredictable patient care demands. In Critical Access Hospitals patient census fluctuates on a daily basis and can go from 5 to 15 during 24 hours. A good example is this morning we have 1 post partum c-section from yesterday, an additional post partum patient, a c-section this morning, and another mom in labor. We need to staff 3 RN's in the OB department for safe patient care. These nurses have to be specially trained to provide care for newborns and obstetrical patients. It is not possible to simply not care for patients. Their safety is compromised when sufficient staffing is unavailable. Also when 2 or more staff call in sick, staffing problems can arise. It is not possible to over hire in a small rural hospital. We do have specially trained nurses available who can care for a variety of patients maintaining competency in multiple specialty areas. While the last resort of many existing ways to manage patient care needs, mandatory overtime should remain a tool to be used in times of extreme circumstances.

In closing, the need for healthcare is unpredictable and hospitals must be able to respond to patient needs around the clock every day of the year. Proactive approaches to the issues surrounding adequate staffing are being pursued. Health care facilities, academia and other stakeholders continue to address the nursing work force. A number of additional initiatives have been put into place so that supplemental staff are available when the need arises. Providing safe patient care is the priority. I appreciate the opportunity to testify today and to respond to what is proposed under Senate Bill 108.

and make informed decisions about who they chose. Also, the State of Wisconsin does not need to add an additional financial burden of approximately $150,000 to a state suffering with such a budget shortfall.

In closing, I want to thank you for listening. Keep in mind that if this legislation were to pass it could be your mother or father, spouse, son, or daughter who is being cared for in a facility who cannot adequately provide care because a nurse called in sick or multiple trauma victims presented to the ER and the hospital was prohibited from keeping staff on board. Who will take care of the patients?

My Anecdotal Story

This is my own experience with mandatory OT when I worked a 24-hour shift during a local tragedy. Though this occurred in Texas, this type of mass casualty could occur anywhere. At approximately 2:30 a.m. on November 18, 1999, the 40-foot (12 m) high stack, consisting of about 5000 logs, collapsed during construction. Of the 58 students and former students working on the stack, 12 were killed and 27 were injured. Within minutes of the collapse, members of Texas Task Force 1, the state's elite emergency response team, arrived to begin the rescue efforts. Rescue operations took over 24 hours; the pace was hampered by the fact that many of the logs were removed by hand for fear that using heavy equipment to remove them would cause further collapses, resulting in further injuries to those still trapped. Students, including the entire Texas A&M football team and many members of the university's Corps of Cadets, rushed to the site to assist rescue workers with manually removing the logs. The Texas A&M civil engineering department was also called on to examine the site and help the workers decide the order in which the logs could be safely removed, and, at the request of the Texas Forest Service, Steely Lumber Company in Huntsville, Texas sent log-moving equipment and operators. Bonfire survivor John Comstock was the last living person to be removed from the stack. He spent months in the hospital following amputation of his left leg and partial paralysis of his right side. Comstock returned to A&M in 2001 to finish his degree.

At the hospital I worked at, St Joseph Regional Health Center, I was assigned to run the temporary morgue. This was where the 12 student who died were brought as they were removed from the stack over the next 24 hours. Our facility was inundated with family, hundreds of students and the media. This barrage lasted for several days and staff at all levels put in multiple shifts to care for the injured and their families. If mandatory OT was not allowed, we would not have been able to deliver and sustain the high quality of care that was needed. Now maybe this would have been an exempt situation according to the statute or maybe not. Maybe there would have been arguments over whether we had the authority to override the law. All I know is that when a crisis hits you do not have time for those discussions because the safety of patients may hang in the balance.

Ivar "Skip" Gjolberg PT
Assistant Administrator
St. Joseph Hospital
Chippewa Falls, WI
715-726-3200

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MEMORANDUM

TO: Honorable Members of the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Sarah Diedrick-Kasdorf, Senior Legislative Associate

DATE: April 22, 2009

SUBJECT: Opposition to Senate Bill 108

The Wisconsin Counties Association (WCA) opposes Senate Bill 108, relating to mandatory overtime hours and on-call time worked by health care workers.

Wisconsin's counties operate several health care facilities, including skilled nursing facilities, hospitals and mental health centers, adult family homes and assisted living facilities, as well as provide health care services in our county jails and houses of correction.

In speaking with several counties about this legislation, managers of county facilities use mandatory overtime as a last resort; in other words, mandatory overtime is required only if no other employee volunteered to work the shift and contracted staff was not available. If facilities are prohibited from mandating overtime, care for residents will be compromised, and facilities risk federal and state citations for falling below minimum staffing requirements.

Although Senate Bill 108 makes significant changes to previous versions of the bill, the Wisconsin Counties Association continues to oppose such legislation at this time.

Thank you for considering our comments.